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ABSTRACT

Grassroots Educare Trust is a training and service organization for community-controlled educare centers. Sharon Hostetler, a volunteer community health worker/trainer, helped launch a 6-day health program for educare workers in South Africa. In post-aparthied South Africa, the preschool field has been identified as an important target group for preventive health care. In a subsequent interview, Sharon Hostetler discusses her experiences developing the 6-day program, in which two trainees from each of the Educare centers participated. The program was developed around the information the trainees asked to learn, which ranged from simple health problems such as runny noses, to major trauma. Information on AIDS and HIV was also added. Among the difficulties Hostetler notes in her interview were the lack of basic teaching materials such as blackboards and electronics equipment; the pressure of covering a lot of material in so short a time, often without enough materials for the size of the group; the need to improvise when resupplying first aid kits, for example, making bandages from old clothes; and the paradox of teaching the concept of health to people who must live in essentially unhealthy environments. She also noted the need for trainees to follow up and make certain their instructions were being followed. The program was successful, Hostetler notes, largely because the trainees selected the content and committed themselves to it. Topics covered in the course as well as supplies for the first aid boxes are listed. (HTH)

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Introducing Health Education to Educare Projects

A Case Study

Grassrots Educare Trust

November 1992

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What follows is an interview between Sharon Hostetler, a voluntary community health trainer with Grassroots Educare Trust and Melanie Steele, a researcher from Grassroots. Editing by Eric Atmore.

Special thanks to **Warner Lambert** for contributing to the funding of this programme, to the trainees and to the community in Albion, Michigan who sponsored Sharon's trip.

BACKGROUND INFORMATION

Sharon Hostetler has been instructing and training for the American Heart Association and Red Cross in Cardio Pulmonary Resuscitation since 1978. She is also a qualified and active State Instructor/Co-ordinator of Emergency Medical Technicians (perhaps best known in this country as 911 operators) for the State of Michigan where she lives. In addition, she has been serving the local ambulance service in Albion, Michigan as an ambulance attendant for the past twenty years. She also initiated, co-ordinated and taught the Kids Cardiac Life Support Programme (KCLS) in the public schools of Albion, which is a programme teaching children healthy lifestyles and First Aid rescue techniques. All of the above is done in a voluntary capacity. She is employed full-time by Albion College as a secretary.

During the year Sharon was in South Africa, she established a health education programme for educare workers of centres receiving services from Grassroots. She was also active in the local Red Cross Association and St. Johns ambulance service, introducing and implementing her KCLS Programme.

The Council for Kids Cardiac Life Support - South Africa

A support group formed by the Albion community to fund Sharon's trip to South Africa. Albion is a small, rural and relatively economically depressed area, whose concern for the South African situation has been stirred by a small but very prominent and respected university, Albion College.

Composed of representatives from local churches, schools, businesses, child and family service organisations, the Albion Rotary Club, Albion College, the local National Association of Coloured People, and other voluntary organisations they raised $16 000 for training equipment, shipping and travelling expenses. This in turn would not have been possible without the support and concern of the people of Albion themselves.

Introduction

Grassroots Educare Trust is a training and service organisation for community-controlled educare centres. The thrust of our work revolves around educare training of teacher aides, as well as organisational development and financial management for preschool committees. At the initiation of a voluntary community health worker/trainer from the United States, Sharon Hostetler, a health programme was launched at the beginning of 1992 for educare workers.

The literature cites many examples of case studies involving the provision of appropriate, affordable and accessible health services. However, there is relatively little input on health education. The interview that follows is presented as a case study of a health education programme for educare workers.

The health context

The Health Education Programme needs to be seen in the context of existing health services in South Africa and current developments in the health field; as well as the status (ie. health) of its target population, viz. the preschool field/child. Central to the ongoing debate around the re-organisation of its national health system toward a more equitable arrangement, is the role of the Community Health Worker. Furthermore, health researchers have identified preschool children as a particularly vulnerable group, compulsory clinic attendance being terminated at age two.

The need for major reform of our national health system is accepted both by the government and the non-government health sector. The existing fragmentation of health administration and service delivery bears testament to the apartheid legacy, where, as in all spheres the system serves inversely with the need. Within the debate centred around this, there is consensus on **primary health care** as the appropriate system/strategy for a post-apartheid South Africa. For it is within this approach that health is viewed within the context of socio-economic and environmental conditions, and health care as part of a broad community development ethos.

At the crux of the Primary Health Care model, is a shift in emphasis from curative, physician-centred services to a more preventive, community-based approach largely in the deployment of lay personnel, the community health worker. He/she forms an essential part of a network/referral system, combining all levels of health workers into a multi-disciplinary health team. However, where the government perceives this as a quick and inexpensive way of extending health servic and personnel to the poorer

communities and medically indigent; and the medical establishment (ie. medical schools, physicians, nurses) sees it as a de-emphasis of their role and a threat to the traditional medical hierarchy, the concept of the Community Health Worker needs to be developed and encouraged as an important category of health professional within a comprehensive national Primary Health Care system.

As it stands, local communities have inadequate health services, whose focus is on curative services by medical professionals who have little association with the communities they serve. By contrast the Community Health Worker is a more accessible and appropriate category of worker who focuses on preventive health, and by establishing and maintaining strong links with the communities, demystifies the profession. This empowers the community to respond more effectively to their health needs.

The Preschool field and Child health

As a point of entry, the preschool field has been identified by health researchers as an important target group for preventive action.

* As compulsory clinic attendance ends at age two, this group of children are often lost to follow-up until they register for school at age six. These being crucial years of development, the educare centre provides access to children whose health status is otherwise largely overlooked.

* While the City Health Department serves registered centres, the majority of children are excluded, since registration requirements/standards are so stringent few centres can comply.

* Health information is particularly important for women as they bear most of the responsibility for childrens health. Certainly in the preschool centres, they are the primary caregivers.

* Educare facilities are therefore an important vehicle for monitoring childrens health. By establishing the day-care worker as a health provider, children receive direct and continuous health care.

While the health workshops described in this text are intended to benefit child health in this way, their objective does not stop there. It is hoped that they form part of the broader goal of "educating day-care workers as a progressive step toward health for all" (Harrison 1991; 22)[1], and as an important catalyst for community development.

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1 David Harrison, An Overview of Children's Health in the Western Cape, Child Health Unit, University of Cape Town, 1991.

Sharon, you came from the United States and at your initiative launched a very successful health programme at Grassroots. Tell us a bit about how that came about, your background in the health field, and how you approached this task you'd set for yourself.

Albion College in Michigan which is where I work, has always taken an extreme interest in South Africa and its problems, so I have been acutely aware of the situation here, and wanted very much to make some contribution. When my husband was offered an exchange professorship at UCT, this presented an opportunity for me to really try and do something here. And so I talked to a number of people about what was needed and what the most valuable contribution might be, Mandla Tshabalala[2] being one of them plus a number of other South Africans at Michigan State University, and it seemed always to be something pertaining to children.

I had recently started a programme in Albion called Kids Cardiac Life Support, which is teaching children healthy lifestyles and First Aid rescue techniques and so my first thought was to bring that programme to South Africa. But I was reminded that the needs at the educare centres were much more basic than that, and would I be willing to adapt it for a more grassroots level which I was more than happy to do.

What did you set out to do? What were your objectives - what did you hope to achieve?

I guess at the beginning my objectives were to teach and share with the community the things that I knew, to do a pilot programme that would show Grassroots an example. But it was also for me to learn myself, to learn of the problems in the community so that I would be able to do a better job. The other thing was to convince these people that the children in their centres are potentially little rescuers, little life-savers, that children have this capability. I think that these goals were definitely met, but it went far beyond that.

So you came out here and decided you wanted to set up a health programme. Did you liaise or network with other health structures to see what they were doing, with local community structures to assess the need? Where did you start? Where did this take you?

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2 Dr. Mandla Tshabalala is the Vice-Chairman of the Grassroots Board of Trustees, and at the time was on sabbatical in the United States, on an exchange professorship between UCT and Albion College.

Well, my initial intention had been - and this is one of the things that the WK Kellogg Foundation[3] in America whom I approached for funding advised me to do, and I thought was excellent advice - to come and learn for at least the first six months if not longer, to see where the need was first, and then to plug into that need.

I already had this philosophy. It wasn't something that they had to teach me, but it reminded me, to find out from the people what is wanted. Now I'm not sure that they had in mind quite the level at which I carried out that advice. I think they had more in mind - find out from PPHC[4], or find out from Grassroots, or find out from SACLA[5] or St. Johns[6] or something like that. But I carried that advice even further, in that I felt it was incredibly important to find out from the people that I was teaching what was wanted.

How did this work? Did the CED's[7] get the people from the community together to discuss it?

Lynette[8] was already working in Crossroads, which is a relatively new area to Grassroots, and it had a lot of new educare centres. They were mostly A centres, some B and I think one C centre[9]. We felt that this would be a good area to pilot a programme, because if I could get the information across under these conditions, if I could make it happen here, then I could probably make it work in any of the other areas that Grassroots works in.

Lynette was already having principals' meetings about once or twice a

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3 WK Kellogg Foundation. Sharon originally approached the Foundation in the United States for funding having been informed by Dr. Tshabalala that locally they were important funders of our work. At present, they fund the educare (basic) training programme for the entire rural area as well as the Rural Outreach programme in three of the five regions that Grassroots serves.

4 Progressive Primary Health Care.

5 The South African Christian Leadership Assembly who are responsible for the largest Community Health Worker project in the Western Cape.

6 St. Johns Ambulance and Domiciliary Service.

7 Community Educare Developers.

8 Lynette Maart, manager of the urban field team.

9 A system of project categorisation used by Grassroots in the urban areas, where an 'A' project represents the least developed in terms of resources, staff training and administration and a D centre the most developed.

month, so she just had me tap into that. I came to one of their meetings, and on the agenda was health workshops. What I did was essentially talk with the women and find out "Do you want a health workshop, do you want first aid, how much do you want to learn?" After that we negotiated - how long, what time of the day, what day - and most importantly, what do you want to learn about? So that group truly owned the programme, to the extent that they picked everything. They picked the venue, they picked the time, they picked the dates, they picked the content. It was to run for twelve weeks, two hours a week. The only thing that changed was that it ended up running for fifteen weeks.

So you started with a pilot programme. How did that inform the existing programme? What changes did you make on the basis of what you learned in the pilot?

Well, I'm doing the same kind of thing now, getting the people together to plan the programme. That ownership was extremely important to the success of the programme. Giving them ownership and making them responsible for attendance and promptness and so forth. That commitment was really important.

However, this first pilot at Crossroads proved to be too loose, because they gave me a list of topics that they wanted covered, and then they would choose, from one week to the next, what topic they wanted to cover the following week. That was very difficult because each week I was having to now go back and get the Resource Centre[10] to help me get the material, aids and so forth that were needed for the next session and write my training plan, and read up on what I needed to know. That really didn't work, it was extremely difficult to do it that way. But that was just one of the things that I learned from the pilot - find out what they want to know and then you sit and try and put it into some kind of logical order. That way you can at least plan ahead.

We've also started doing all day sessions, that is 9.30 to 3.30 over a six week period, and I think that these workshops are running more smoothly. The agenda has always been to review the previous week's session, have the workshop and then evaluate and feedback on how they found the day. When I only had three hours and I was covering

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10 The Resource Centre offers a library of children's books and toys, audio-visual material and equipment and a reference library relating to Early Childhood Education and community development. There is also an anti-waste depot for projects with limited financial resources. The Centre services the organisations own staff, as well as preschool educare projects, students and community organisations in the Western Cape who work with young children.

respiratory problems for instance, I would start out with runny noses, but I wouldn't be able to get down to the throat or chest problems. By the time we had reviewed the week before, time was running out, and so it took about three weeks to do something that I'm now doing in one day. It's the same amount of time, but it's much nicer just to have it flow, and the review sessions are flowing much better too. We had to negotiate to have them there on an all day basis, but I like it this way, and I think the women like it this way, because they feel as if they are gaining much more new stuff and that's what is exciting to them. They like to be able to show what they've learned from the previous week, but they also like to get all that new information.

What was covered? Tell us a bit more about how this process went.

Essentially what I did was put newsprint on the wall and ask, "what is it that you would like to learn?" It started out slowly with colds and runny noses, then fevers and runny tummy's, and then very soon we got onto cuts and bleeding. And then I would ask, okay do you want to learn about major bleeding or just minor bleeding and each group wanted different things. Crossroads was much more interested in health problems and in minor injuries, whereas Langa and some parts of Khayelitsha have been much more interested in major trauma. They wanted to know knifings and gunshot wounds, big falls and car accidents, and so to me this is a beautiful example of the fact that yes, you are teaching teachers and principals of educare centres, but you are also teaching a woman, a person, who has a family, perhaps a lodger, older children, an extended family. And then they also belong to a community. So this person does not want to sit there and learn only what is going to be used in the educare centre, they are wanting to know things that are pertinent to their life, period!

Do you think that this discrepancy between areas in the choice of content is a case of different environments, different circumstances dictating different needs or priorities?

I think partly yes. For that first pilot, the programme was still in a very formative phase, very much in the mode of children and preschools and what pertains to that, which is mostly fevers, runny tummies etc. I never suggested any of the other trauma-associated things, which I did for the other groups, and as soon as they thought about it, yes, they wanted it! So I think perhaps I was a little unfair in that sense. The Crossroads group was just holding back. The other possibility is that they are in a less violent environment, although I don't know enough about these

areas to say that.

The only problem with this process is to try and cover everything, because each group manages to pick up on everything that the previous group wanted, as well as adding a few things of their own, as I'm making suggestions. And it's getting to the point that it's not possible, because it's only six days.

So for the most part, you've really been guided by what the group wanted. Did you not make any changes or additions that you felt were appropriate?

I believe I added in each of the groups something that they hadn't included, which was AIDS. They were not even aware of how the HIV virus is transmitted, and so it's important that when we started talking about blood, even if it's children's blood, that they understand how it can be transmitted. That starts right out with sanitation as to how germs get from one person to another, that they're air borne, blood borne, by mouth and so forth. That just became absolutely imperative and I felt very strongly about including it.

How successful do you think that was, towards AIDS awareness, as an AIDS awareness strategy?

I think it was extremely successful, not that these women are all going to start using protection, condoms and so forth, but I think that for them to understand the concept, to understand what is happening, that has to be digested for some time, as a first step. Some of the women have heard it before, everybody in that audience was not brand new to the topic, but it reaffirmed it or it explained it a little bit more in a slightly different way so that they understood it better. One woman that I talked to came in very excited. She had been to another AIDS workshop and she said, "Sharon, they were telling the same thing you did, only I really understood it" - because she had had the background for it and she was extremely excited about it. Some of the women said "no, I'm not sexually active, I'm not going to need these, but I'm going to give them to my son." Well you know that this woman is not going to give them to her son without explaining what's going on and so I believe that this basic empowerment, through knowledge, just as with anything else that they've been learning, is going to have an impact in some way. This woman is going to end up teaching others, she might be doing it from the church, she might be doing it from a club or something, but she's going to be leading AIDS workshops, there was no question in my mind that this was what was happening. These women are not just sitting

there learning it for the preschools.

The choice of content is a difficult one. In terms of the holistic health perspective, ie. one that views health in the context of socio-economic and environmental conditions, people need to be informed of a whole range of health criteria. On the other hand it is argued, they might go away feeling more confident and prove more effective, knowing less, but knowing it more thoroughly. What is your feeling on this? In terms of training people to maximum effect, do you favour an approach where you train in a very broad range of things, or one where the focus is more limited, but more in depth?

Well this has been my main frustration, and it is becoming even more frustrating as their lists are getting longer. What I was doing in the Crossroads pilot, was the latter, really training in-depth. In Khayelitsha, their lists became longer, and so I tried to do both, and that was the frustration for me - that I wanted them to have both. On topics that I really felt were critical, such as the ABC's of airways and bleeding, choking and consciousness and so forth, I went into more depth. Sanitation and germs was another that I really did thoroughly, and some of the items that I felt that they could learn elsewhere such as nutrition and runny tummy's, these are workshops that I really didn't go into quite as much detail. I felt that if they had a really good foundation they can sit in on a workshop from any number of organisations and be able to tap in on what is being taught them there. And so I really tried to do both.

I want to talk a bit about your method of training - by that I mean your personal style, your approach.

The way I teach is through hands-on, role-play, demonstration and so forth. But what I found here, by having no blackboards and often no electricity at some of the venues, the overhead projectors and audio-visuals, the slides and some of the other things that I was accustomed to using just wouldn't work. So it forced me to carry this method even further than I might otherwise have done.

I believe - I know everybody has heard it - that what you see you quickly forget, what you hear you know for a little longer and what you see demonstrated, you know even longer, but that when you do it yourself, you remember it. So I try to keep that in mind as I plan all of my sessions. As I'm sitting there I think, "here is a concept, how can I get it across, what can I do other than just talking, what pictures can I show,

what demonstrations can I do, **how can I make them do it**", and then I get them involved. Some of the topics are very easy, such as the first aid things. It's extremely easy to get them doing it. They have to bandage, they have to log-roll the patient, they have to open their airways, they have to role-play the choking, that's extremely easy. It's much harder when we start getting down to the germs and runny noses and so forth. I use David Werner's book "Where there is no Doctor"[11], I think it's a wonderful book and I used it a lot for suggestions. I think he mentioned sniffing salt water instead of giving nose drops. Well that's a wonderful alternative but they had to **try** it in the class. And the same with gargling, if I'm going to teach gargling, and they are going to have to teach the children to gargle, then they have to make sure they can gargle. So I made them gargle. Same thing with the home-made cough syrup, I made it up in the workshop, and had them taste it. Again with the runny tummy, you talk about making the solution taste like tears, well I poured it into little cups and they tasted it. Because if you oversalt it the child is going to reject it, so they need to know how it's supposed to taste. And they will remember it. So this is how my methods have gone. For each thing that I've tried to do, I've tried to think "how can I make them do it", because if they do it, they'll remember it.

I think that the "homework" assignments were very valuable in that sense. By having them go back to the centres each week and teach the children to gargle, or take their temperatures, they are both educating the children as well as having to repeat the "doing".

I have found that there is nothing that will make a person remember something more than by having them teach it. If you have to teach something, you really have to know it. So I have actually had two reasons for that. One is that this is going to make them remember it, the second is that it's going to mean another person learning it, which is the child. I believe very strongly that children are under-utilised, that they have capabilities that are never tapped. These children in the centres, the four, five and six year olds have the capabilities of being little life-savers, they just have to be taught how. So part of the homework assignment would always be to teach the children this or that, and then to show me as part of the review session, how they taught them.

I would very much like to pursue this even further. I think it is a very

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11 Where there is no Doctor, A Village health care handbook, by David Werner, Macmillan Publishers, London 1979.

neglected area; children can learn to stop, drop and roll if they are on fire for instance, and once those children have learned that, they take that information home. They've learned something fun and exciting and they share it at home, so there is an even bigger audience that's exposed to these things.

Yes, you mentioned earlier on that one of your objectives when you started out was to put this across, to convince your audience that children have this potential. Do you think that you've convinced them, that children have that potential?

Yes, I think that they were surprised by how much the children could learn. They hadn't thought of it, it's just human nature. I mean nobody goes around thinking children can learn something that is usually reserved for adults. Asking them to do it and come back and role-play it, proved to them that this is indeed possible. So it's just a matter of putting that thought, that concept across in the first place. Once they had learned that, once that had sunk in, then almost everything I asked them to teach the children was "yes, yes, yes!!"

I noticed that you always used warm-up exercises to open the workshops.

Warm-up exercises are a good way of getting everybody away from their tea or from talking, to get the session started, to come together as a group. It can just be a sharing of information, telling your name and a bit about yourself. It can be a game, or it can be turned into a review exercise, like standing in a circle and having to help the person next to you who is "choking". And then sometimes the warm-up exercise is just getting the blood circulating, making sure that everybody is alert and awake. So I found the warm-up exercise very valuable and you can make it fun. It's a good note to start off on, it sets the mood for the day.

Can we talk about the trainees? I gathered that most of the women who attended were the principals of educare centres, and that there are some problems associated with that. On the one hand, if you empower the teachers or the teacher aides, the principals feel threatened and tend to block it. On the other hand, because the principals spend comparatively less time in the centres, it's less appropriate to train them in isolation.

Right, this is why we asked for two people from each centre, the principal and one other person.

We had this experience with one of the principals in Crossroads, who did not attend the workshops and sent two of her staff instead and it became very obvious that this was what was happening. She had said that she didn't need to come because she had had first aid training, but it was so apparent that these women were learning so much more than just first aid, and so she made it very plain that she was putting that first aid box where nobody was going to have access to it. And yes, many of the principals are gone a lot of the time from the centre for one reason or another, and so it is very important to have another staff member(s) from the centre trained.

Another problem that we're going to have to consider is the staff turnover in some of these centres. The women that we've trained have this knowledge now, and that's wonderful, they're going to use it somewhere, but it may not be in an educare centre. And so I think that the need is ongoing, because there will constantly be new people in these centres to train.

In having two people per centre, how does this affect the size of the groups?

Well, in Crossroads I was working with approximately thirteen centres which meant twenty-six people, but by the time I got to Khayelitsha word was definitely out, and in one group I had thirty-four women. This was really too big but I couldn't bear to tell some of these people to go home. In terms of size and the number of mannequins[12] it's nice to have twenty or less, because then you can have a group of ten do a role-play, followed by a second group of ten. Whereas in a class of twenty-six, you have to have three groups role-play three different times, and this takes up precious time. Ideally it should be between sixteen and twenty people. But the need is so great that I didn't have the heart to say no.[13]

The first aid kits[14] - each preschool received a first aid kit as part

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12 Life-size infant and adult 'dolls'. They are specifically designed for health and first aid training, in that they have all the relevant anatomical features intact.

13 Officially all trainees admitted to the course were from Grassroots associated centres. However once word was out that the health workshops were being run there were numerous requests from other centres in the respective areas to attend. Because of the implications this had for the size of the groups the decision was thrown open to participants. They elected to have them stay.

14 The provision of first aid kits for each centre in attendance was an important component of this course. In order for preschools to receive certain subsidy's they have to be registered, for which they have to meet a number of requirements, one of them being the possession of a first aid kit. They were therefore an important part of the motivation to

of their training, but I noticed that they were very central to the course. You taught around them a lot, building on their contents week by week according to what was covered that day, so that by the end of the course they had a very thorough knowledge and understanding of the contents of the kit. I also noticed that whatever pharmaceutical remedy they included, you always tried to offer a home-made alternative, because of the expense of resupplies.

Absolutely. The centres in which I have been training are amongst the poorest centres, so I am acutely aware of the conditions in which they operate. And this is something that I think is extremely important and that is - anybody who is going to be teaching somebody else needs to see where that person is coming from, they need to see the physical conditions in which that person lives and works. So I was not only interested in the preschools. I did visit the preschools and that was very important, but I also looked around, "where do you live", I mean, "what kind of conditions are you coming from each morning", and I found that extremely important because we're teaching the total person.

I walked into these preschools, and some of them were saying these children are hungry today, we didn't budget enough, or we didn't get sufficient fees this month, or the children were told to bring food from home and they're not bringing enough. And I heard that often enough to convince me that these people are not going to spend money on first aid supplies when they don't have enough money to feed these children. So immediately my first thought was where to get these kits resupplied, and everywhere I turned the answer was "you're not, it's not going to happen". Well I am still not convinced of that, but it made me realise that these people are going to have to improvise.

Like the home-made remedy's, bandages and splints and so forth...?

Yes, that's when we went to the old clothes for bandages and dressings, and teaching participants that it's not just a matter of taking old clothes that you have stuck in the corner and turning them into bandages. You have to make sure that they are washed and dried in the sun, and then ironed before they're turned into bandages. So I have brought samples of old clothes that have been made into bandages, as an example, and then I have bought old clothes themselves, as well as pieces of material from the scrap area in the Resource Centre and told them, "homework

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Warner Lambert for the funding of this programme. See Appendix for list of contents.

assignment, you make bandages and dressings and bring them and show us". And I did that for several weeks, they had to bring them and show me, and then they had to start collecting their own scrap. This just got their thinking processes going. You can find an alternative for almost anything. The splints were pieces of wood from the tomato crates that you get from the vendors, wrapped with a piece of material and tied; the neck splints were just some newspaper rolled and tied; the stretcher can be a blanket or a chair, or a piece of a table. The cheapest way of disinfecting - lifebouy, or jik, how to dilute jik to stretch it. And we tried each thing out during the course of the workshops.

In terms of resourcing and supporting the workshops, what was required? How was this met by the agency? You have mentioned the Resource Centre and the CED's. Can we talk about that?

Yes, it's very important to me to work as a team. Anybody who is going out as an island is doomed to failure. The CEDs are absolutely essential to the success of the programme. I asked them to meet with me ahead of the programme, to find out what I expected from them and what they expected from me. I had them take me out to the centres. I asked them to attend all of the workshops, because if they don't know what the people are being taught then they are not going to have any real feeling for what they need to see being implemented in the centres.

At the same time, they are learning themselves. No matter how knowledgeable one is on the subject, one can always learn new information, or new ways of teaching. I think there is always room for that. So that is one of the things I have asked of the CEDs, that they attend all the workshops, and do the follow-up. Because no matter how excited these women may be about a workshop, as human beings they will tend to let other necessities and crises come in and take priority. So I think it needs to be maintained by the CEDs, through regular follow-up. And it is the CEDs who will have to work with Margaret[15] on finding a source for some of the resupplies, because certain things we can't make or substitute, like Panado etc.

And the Resource Centre?

Yes, they did so much. And they knew where to get things. By working very closely with them they immediately picked up on what I needed and what I was trying to do, and so they were extremely proactive in getting

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15 Margaret Louw, appointed to train and co-ordinate the health programme on a permanent basis.

whatever it was that was needed. Elaine[16] knew which books to pull out for me to take home and study. Anita[17] knew which companies to phone to try to get the pieces of material or the scrap or whatever it was I needed. If something came into the Resource Centre that looked like it might be needed or useful for the workshops, it was saved for Sharon! And when it came to making bandages or dressings, I couldn't possibly do all that, and so the Resource Centre did all the cutting and rolling. The trainees had to do make their own as I've said, but we had to provide the initial samples for their kits of the things that I wanted them to use and to make.

And then things like nose wipes. I just want to tell you about a particular incident because it illustrates my point about the need for collaboration with the CEDs, and the Resource Centre. In visiting the centres I realised quickly how many runny noses are out there, and nobody seems to wipe them. Or if they do, it's usually just one piece of material that's used to wipe all the childrens' noses. So that was something I felt was a real need and the only way you're going to get runny noses wiped is to have some tool for them to wipe with, and this is not something they can provide for themselves. And so some of the material that came in and looked like it would make fine nose wipes was cut into big stacks of a size that was just right to wipe one child, once only, which I took to the workshop on runny noses. And I talked with the women about this idea, that after you use one, you put it into jik water and rinse it out for use the next day; and was it a good idea, "oh yes", everybody thought it was a good idea. But when one of the CEDs went out to the centre - language problem here - one of the women had not quite got the concept. You see these nose wipes were made from very brightly coloured pieces of material, and here the principal, instead of keeping them for herself to wipe the childrens' noses, had given a piece to each child. But the child didn't really understand that they were supposed to wipe their noses with it, but they knew that it was theirs. And so she said she saw all these little tots running around tightly grasping these brightly coloured pieces of material, and wiping their noses with the back of their hand! And so the next week we talked about nose wipes again and how they really need to be used! So this is what I'm saying about the need for feedback from the CED, not just in the evaluation session at the end of the day - I needed to get that - but I also needed them to go out to the centres and find out if they are using soap when the children wash their hands after toileting and so forth. And if not, why

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16 Elaine Atkins, librarian.

17 Anita Katzen, Resource Centre administrator.

aren't these things being implemented.

Speaking of communication, was language a problem? I noticed that you always had someone from the group to translate rather than the CED.

I don't think it was a problem. I think that in some way, not speaking their language worked for me rather than the other way around. It forced me to slow down, it made me have to do more showing and doing, and in this way ensuring that they understood. It meant that somebody had to interpret, and this in turn meant that those who understood it in English - even part of what I was saying - heard it once, and then they heard it again from the interpreter. And because it was someone from the group, they were more than happy to correct her if she wasn't telling it quite right, or to add things that she had neglected to tell. So they heard it twice, and I think that was extremely valuable.

Yes, I think it also encouraged their participation, and that sense of ownership that we talked about.

Right. And then the questions almost always came in their own language and the interpreter would have to interpret to me what the question was, so I think this gave them more confidence to ask what they wanted to ask. So no, I don't think language was a problem, it was actually a positive, in that sense.

You gave out a considerable amount of written material and other hand-outs during the course of the programme. Some were quite advanced, others were very user-friendly. Did you develop these yourself, or were they adapted from other sources?

I had been made extremely aware of the need for simplicity, the need for pictures and simple statements. These women didn't necessarily want things in Xhosa, they have learned to read and write more in English than they have in their own language, and so a lot of them requested just simple, illustrated English. My community[18] had appealed for any books on first aid, and so I went through everything I had and then cut and paste, usually adding my own explanation underneath, always trying to keep it visual and keep it brief and simple and I have done that for each session. For those that wanted more

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18 The community in Albion, Michigan who formed a support group to help raise most of the money for Sharon's trip to South Africa, including the apparatus such as the mannequins which she used during training.

information I have given additional printed material which I got from other health organisations, on burns and poisons etc.

I also included my own notes. I didn't want them taking notes and so the only way I felt I could ask them not to do that was by offering mine. So after each session they would get all of this material which then went into a file, and keeping their files up to date was part of the course.

The only problem with this has been that at times the notes they received are a little more complex or a little different to my explanation and they would query that. But that's a nice opportunity of explaining that there is no one approach to health, that it's not an exact field and that often the things that they are doing are just as good as what I'm teaching them. So this is pointed out over and over again, that I'm not there to tell them the only way to do things, that we're sharing information.

What about the venues? You are currently running the workshops at Grassroots although the previous workshops were based locally, in the townships.

Yes. The CEDs have chosen the venues. I really liked the idea of the women being in a venue that they are comfortable in. I feel that if it's in the township they are going to feel more at ease, they are going to relax and learn more, than if they have to worry about bus fare, taxi fare, an hour to get into Grassroots, an hour to get.home. It does mean a lot of extra work for me, in terms of loading up the car, having to take out all the training materials, but there is only one of me as opposed to twenty to thirty participants, and I am mobile. So I'd far rather go to them. I think it's very important to show a willingness to go to them. I think this makes a big difference, they see it as my commitment to them, and to the course. And this sets a precedent. In return I expect their commitment. I expect them to be there on time.

The reason we've changed the venue to Grassroots is that having done locally based workshops, we now have centres from different areas together in one workshop.

How is this working? I think it's quite useful to talk about what you've mentioned to me previously, about the dynamics of this diversity for you as a trainer.

Well, there has always been a diversity in the groups that I've worked with. It may have been in terms of education, literacy, rural or urban

background and so forth. However, I now have people from Guguletu, KTC and Nyanga, some of whom are from squatter areas, together with Mitchells Plain, who are comparatively quite affluent. By that I mean they all have a roof over their heads, water on tap, flush toilets, electricity etc. And on top of these differences in living conditions, there are also differences in language, culture, education, ages, literacy levels and so forth. And I worried about that, I worried about whether or not these people were going to be able to touch each other, to share with each other, whether I as a trainer was going to be able to deal with this group of twenty-six people from such diverse backgrounds.

Initially it was a bit stiff, with only the women from Mitchells Plain really speaking out or asking any questions. But we had started with the airway session, and by the time we got to role-play choking, this proved to be an excellent way of breaking down barriers. I mean nobody wanted to touch anybody, to put their arms around each other, but it really broke the ice. So by the time the workshop was over, there was much laughter, everybody had been in it together, everybody's knees hurt, everybody had had to lay down, to straddle a person, to have someone's fingers down their throat. They were in this together now, and so airways was a good thing to start with, to get the group dynamic going in the very first workshop and then build on that. Because its not only that basic knowledge that they are getting out of the workshops, it's also the camaraderie that is so valuable to their learning experience and the learning process.

Something that struck me during the course of these workshops, was what the implications might be for someone like yourself, a health specialist, dealing in the subject of health, in amongst what is essentially a very "unhealthy" environment. In other words you are educating women about how to live out a healthy existence in an environment which negates everything that you have to teach them. I'm referring here to the squatter areas which is largely where you have been working.

Well, this was very apparent in Khayelitsha, where it was not only their life in Cape Town that's difficult in terms of water and sewerage and so forth, but it was also "the Transkei", "the Ciskei", "back in the rural areas", "what can we do?".

I can't make a difference to their living conditions, but what I can do is explain to people, to get them to understand the basic concepts of germs, where they come from, how they enter the body, what they do once they're in the body, how the body fights those germs. If they can

understand those basic concepts, then they can make more informed decisions as to how they can address their situation.

In other words you're just there to give them the information....

Right, I can only give them the information. Then they will ask me a question like "how can we do such and such" and that's a question that I won't answer, I throw the question back at the group.

Like the cow dung on the floors?[19]

Yes, that's a beautiful example of that. I have seen the floors they make from this dung, and they are beautiful, but they need to know what the implications of this are, and then they can make their own decisions.

Another good example relates to water. I am really big on water - both for internal and external use - and one of the women from the Crossroads group had convinced me that the water was too far away from the educare centre for her to provide enough for the children to drink **and** to keep clean and so forth. So I threw the problem at the Khayelitsha group, many of whom don't have taps in their centres and these women had no sympathy or excuses for this problem. Their feelings were that if you know you need water and it is a priority item, then you manage to get yourself several buckets, and you get the children involved as part of their daily routine, to go and fetch water. Or "carry it on your head" was one of the suggestions. So they came up with their own solutions.

Ideally, field workers - be they "specialist" trainers or community educare developers - are "indigenous" to the communities that they work with. There is a commonality, a cultural link with the people that they serve, which both equips them and qualifies them to do this type of work. Quite obviously, you represent a complete departure from that ideal and yet despite this, the programme has been very successful. How do you think you bridged that gap for yourself?

I think it may have something to do with the fact that I came to South Africa because of a concern about the situation, a very deep concern,

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19 This was a discussion generated by one of the groups during a workshop. It is common practice in the rural areas to make floors with compacted cow dung which is then dried and polished. It was raised during a discussion about babies and how they being particularly susceptible to germs, are at greater risk in such instances, particularly during the crawling phase when they are constantly picking things up off the floor and putting them in their mouths.

it was not just a superficial thing. I really wanted to do something to try and help the situation, and I think that this made all the difference. I think that they picked up on this without me having to consciously bridge the gap in some way.

Yes I would agree with that. It was obvious right from the start that you had a very good rapport with these women. I observed a great deal of trust and commitment on their part, which is not a given. My own feeling is that this had a lot to do with the depth and sincerity of your commitment, which was very apparent.

This brings me to my next question. It has been said that the success of a programme is never merely evidence of need, or the magnitude of need. That the one doesn't guarantee the other. So often programmes depend upon the charisma and vision of the trainer. Given the need for model programmes that are replicable, that can go to scale, what else do you think is needed to ensure the success of a programme, apart from this personal dynamic?

Firstly, I think a person needs to love what they're doing. You need to enjoy teaching, and you need to enjoy teaching whatever it is that you are teaching. I think that would be necessary for anybody to be able to make an impact, that you are coming in with something you feel is interesting and important and that you want to share.

I think it's also important not to think that you as the trainer, have the answers to everybody's problems, or that your way of doing something is the only way. I think it's extremely important to respect the participants. These women, if they had had the opportunities in life that I have had, would have been doctors and lawyers and leaders. The intelligence is there, it's only the fact that they have not had the opportunity to do something with it, to develop it. It's important to realise that collectively, your audience can have just as much knowledge as you do. It's a respect for that kind of thing. And you need to tap in on that, get them to share what they know with you, just as you are sharing what you know with them. Just because they do it differently does not make it wrong at all. Make that very clear, make that very apparent.

I think that what you mentioned earlier on about ownership is also relevant here, I think that was tremendously significant to the success of the programme.

Yes. This was their programme, they planned it, they selected the content, they committed themselves to it. We kept attendance rosters

of the course and when I looked at that roster for Khayelitsha I was amazed at the attendance rate, despite the fact that there were no conditions attached to their attendance or non-attendance. So to me that was a real affirmation of their commitment to learning.

We've spoken about the weekly review sessions, and the follow-up by the CEDs in the centres. Can we talk now about the formal evaluations, culminating with certification and graduation?

Yes, as I've said, each week I felt it was very important to review, and the way I would do this was break the group up into smaller groups of three or four, who would then have to demonstrate a couple of things. There were two reasons for this, the one is that as I've said, by doing it they learn it better, and the other is that for many their English was not that good, and so the only way they could show me that they had learned something was by demonstrating it. I would take all the props from the previous week that they might need, they would get a few minutes to prepare, and then each group would have to answer one of three or four review questions. In this way they were getting used to this role-playing, without any evaluation going on, just a sharing and learning of information. So by the time the seventh week came, they were very accustomed to this process, and to demonstrating for me and the group.

For the final evaluation, I planned thirty to forty broad questions, not short answer questions - explain how you would prevent germs from spreading or write a menu that includes all the food groups, demonstrate what you would do if a child was having a seizure - and I brought all the props that they could select from. They were divided into six different groups, and each group had to answer six questions. The group was responsible for answering but a different person had to answer each time.[20] This may not be the most perfect way of evaluating but it gave me a very good feeling as to what they knew, and it proved to them how much they knew. They got tremendous pride and satisfaction out of seeing each other stand up there and demonstrate this knowledge and ability. They may not have done it as perfectly as an ambulance attendant would do, or someone from the clinic, but that's not what I'm looking for. I was looking for that basic knowledge of knowing what to do, even if it's not in perfect sequence. They are going to save lives and that's all I wanted to say "pass". They are not being awarded a Red Cross certificate. We are giving them a certificate saying this person has had training in the following, and we listed the different areas of

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20 In addition, participants were required to identify the contents of their first aid boxes, and their use.

health and first aid that they had received. Next to each item is a signature so that if they missed that session it would indicate that. It also means that they can attend those outstanding sessions by slotting into the next course of workshops, and have their certificates signed and completed.

And the graduation?

I think that the graduation ceremony was extremely valuable. We tried to make it a celebration, because it was a celebration, we were celebrating an achievement. And they looked forward to it - it was their party, as with everything else in the programme. Yes, Grassroots was helping out with the cost, but they also contributed something towards it, and they planned it. They planned the menu, they helped with the preparations, they dressed in their traditional outfits and it was a time of singing and dancing and happiness. For some it was the first certificate they had ever received, for others it was one of many, but it was fun and important to have that acknowledged. They are all working women who had given up time and energy to attend. It was not only us who had put work into these workshops, they had worked too, and it was something to be proud of. And that came through very clearly. As each name was called and they came up for their certificate, they were asked to start a song, and then the rest of the group would join in, and once again that made it theirs.

Yes, I thought that singing was also a nice way of breaking the formality, and the repetition of sitting through one person after another coming up for their certificate. Yet at the same time, having guest speakers lent it the formality, and the seriousness that it deserved. It said, "this is an important day, it's also a celebration but it's serious too."

Yes, it was joyful, but it also meant something. A milestone has been crossed and we're celebrating acknowledgement of that.

We have talked about the successes of the programme. In retrospect, is there anything you feel could have been done differently?

I think that **more** needs to be done, not necessarily done differently. I would have liked to see the day hospitals more involved in what we are doing. I think in that sense, having the head nursing sister from the Khayelitsha day hospital attend the graduation was very constructive. She came in at the tail end of their evaluations, and she was very

impressed with what those women knew. She has since requested some follow-up to that as a first meeting. And this is the kind of thing i think we should do, make the day hospitals aware of the kind of training that these women have. They are not Community Health Workers, I teli them from the beginning that they are not going to be Community Health Workers by doing this course, but that they might want to become one, and right now they are probably some of the most skilled people in their communities. And if we can establish greater co-operation between the day hospitals and these communities, then I think that might be where some of the resupplies could come from, and this would really make a difference. So I would like to see more networking happening.

What other vision do you have for the programme?

In each of the groups that I have taught there has always been one or more outstanding women; their grasp of the topic was superior, they were very capable tranlators, and there was a greater interest, a desire to learn more. So I would like to see those people brought on board. Have them assist in the workshops so that they gain more confidence in the subject, and have that person operate as a resource person for their area, a "bare-foot" trainer, doing regular follow-up. It's quite evident that these women are respected by their colleagues, and by their communities, and have a potential that's just not being utilised. Alternatively we can start a more advanced course for some of the graduates. I don't know exactly how it would work yet, this needs to be thought out more, but it's just something I think needs to be looked at for the long term.

You have commented to me on a number of occasions how much you have learned, and how you continued to learn throughout your experiences here. What sorts of things are you referring to?

I have learned a lot of values from the Grassroots staff that I have worked with, things that I already knew, but that needed to be developed. I mean I already knew that you don't give a person a fish you teach them to fish, I already had that. But it's more about empowerment, about how to empower people, how to train. I have done training courses, but they were nothing compared to what I have learned by watching other people train, and by having other people watch me train and feedback on that. Sue[21] and Lynette would sit in on the early

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21 Sue Bailey, a Community Educare Developer.

workshops and then we'd brainstorm it, and they'd make suggestions. So this helped me to improve my methods, both from observing others and from their observation and feedback of myself.

The other thing I have learned is the importance of pride, of not losing your pride just because you're poor, and again this is something I have learned from Grassroots. I mean I want to give, I want to give people everything. But it was learning to recognise that as a band aid kind of thing, that they really need to pay for certain things. For instance, that big party that we had in Khayelitsha on graduation day, Harold[22] had asked everyone to bring R2 each week from the beginning, towards the cost of that party. In this way it became theirs', and it gave them respect, it wasn't just something given to them. So that's the kind of thing that I've learned and that I will take back to the States with me.

Were there any spin-offs, by that I mean unintended things that came about as a result of the programme, that you can think of?

Yes. I don't think I had anticipated the extent to which these women were empowered by this information. It wasn't just a matter of gaining first aid knowledge, but learning skills which gave them a confidence that spilled over into other areas of their lives. Because when you gain confidence in one area of your life, it spreads to other areas of your life too. So I hadn't realized the extent to which this programme would empower them in this way.

Although essentially we were training these women in their capacity as preschool teachers, I think its going to go way beyond that. At the evaluation, one of the women said how much they had learned, that they couldn't possibly keep this information to themselves, that they would have to share it with the community. And so there are potentially twenty or thirty Community Health Workers out there. That is not what I set out to do, but to some extent that's what we've got.

One incident that put all of us on top of the world was after the very first session in Khayelitsha which was on choking and rescue breathing, there was an incident in the townships where a shack was overcome by fumes. There was a child who had stopped breathing, but one of the women who was on the course was there, and she knew what to do, and she did it, and the child started breathing! She saved its life! Just from having that one session!

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22 Harold Coetzee, a Community Educare Developer.

Was this one of the high points do you think, one of those times when you felt you were really getting through?

Oh absolutely yes, although there were other incidents subsequent to this, where they proved themselves in similar circumstances and life-threatening situations.

Any frustrations?

Only time. The fact that there is literally only six days of training. I would like to teach them much more than I am able to teach them in this time and I find it difficult not to try and jam too much into those six days. I get excited and I speak too fast, trying to get more in, and that's not a good thing. I have to constantly slow myself down and to say, teach them well, pick out the most important things and teach that well.

Any last comment you would like to make?

Yes. When I evaluate people in America I always ask myself, does this person know enough to take care of a child or a baby that is choking or that is dehydrated and could die? Would I be happy for this person to take care of my husband if he has a heart attack? As an evaluator for both the state of Michigan and for the ambulance service, those are the kinds of criteria that I use, and I have used the same criteria here. Having watched these women go through their training and evaluation, I really feel that they know it and I have told them, if I am ever in Khayelitsha and I am hurt I really hope that one of you are around because I believe that you can take care of me and that you can take care of me right.

APPENDIX

COURSE CONTENT

WEEK 1

Airway

- Rescue Breathing - adult/child
- Choking (conscious) - adult/child
- Choking (unconscious) - adult/child
- Drowning
- Fits/Seizures
- Poisons

WEEK 2

Airway

- Rescue breathing - infant
- Choking (conscious) - infant
- Choking (unconscious) - infant

Bleeding

- Major bleeding
- Impaled objects
- Sucking chest wounds
- Internal bleeding

Consciousness

- Shock
- Fainting

WEEK 3

Detailed check

- Neck/back injuries
- Fractures/splinting

Evacuation

- Moving the patient

Burns

- Major/minor

Minor injuries

- Minor bleeding
- Sores
- Smashed fingers
- Sprained ankles

WEEK 4

Nutrition

- Malnutrition
- Clinic Cards (Road to Health Charts)

Gastro-intestinal

- Dehydration
- Worms
- Teeth

WEEK 5

Sanitation/Germs

- AIDS/Hepatitis-B/Syphilis
- Immunization
- Fevers/thermometers

Skin problems

- Ringworm
- Thrush
- Eczema
- Impetigo
- Lice

- Scabies

WEEK 6

Respiratory problems

- Colds
- Stuffy noses
- Ear infections
- Sore throats
- Coughs
- Asthma
- Pneumonia
- Tuberculosis
- Smoking

WEEK 7

Evaluation and Certification

FIRST AID BOX SUPPLIES

EQUIPMENT

Syringe for removing mucus
Oral thermometer and instruction card
Cotton wool
Triangular bandages
Medicine spoons
Gauze squares
Gauze rolls
Surgical tape
Safety pins
Scissors
Rubber gloves
JIK
Lifebuoy soap

MEDICINES

Potassium Permanganate and colour card
Dettol/Eusol
Betadine/Podine
Vaseline
Zinc Ointment
Whitfield Ointment
Gentian Violet
Benzyl Benzoate (Ascabasol) and instruction card for scabies and lice
Mercurochrome
Calamine lotion
Vitamin B complex
Benylin expectorant and instruction card
Panado (Doloral) and instruction card
Lemon juice/honey/liquor instruction card
Gargling instruction card
Oral thermometer instruction card

IMPROVISED

2 litre ice-cream container
scrap squares for dressings (sample)
scrap cotton for dressings
scrap rolls for bandages (sample)
scrap cotton for bandages
scrap cotton triangular bandages
scrap small pieces of material for nose wipes
scrap material for hankies
scrap material for face cloths
plastic bags to substitute for rubber gloves (sample)
litre container (to make re-hydration drink)
notebook to hold handouts
sample rigid splint (from vegetable crates)
First-aid box (with lock)